TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
American Zurich Insurance Co

**MFDR Tracking Number**
M4-16-0733-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
November 16, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** Memorial Compounding Pharmacy's bills are not being processed in accordance to Texas Guideline Rule 133.240 Medical Payments and Denials.

**Amount in Dispute:** $489.96

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier maintains their denial of the medications as they were not preauthorized. Preauthorization is required for drugs indentified with a status of "N" in the current edition of the ODG, any compound that contains a drug identified with a status of "N", and any investigational or experimental drug as defined in Texas Labor Code §413.014(a)."

**Response submitted by:** Broadspire

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 24, 2015 | Baclofen<br>Amantadine HCL<br>Gabapentin USP<br>Amitriptyline HCL<br>Bupivicaine HCL | $489.96 | $489.96 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.540 sets out requirements for use of the closed formulary for claims subject to certified networks. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims subject to a certified network.

3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier denied the services in dispute with the following remark codes:
   - 210 – Payment adjusted because pre-certification/authorization not received in a timely manner

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The carrier denied the services in dispute as 210 – "Payment adjusted because pre-certification/authorization not received in a timely manner." 28 Texas Administrative Code 134.540 (b) states,

> Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:
>
> (1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
>
> (2) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
>
> (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Review of the submitted claim forms finds;

a. Date of service July 24, 2015, Baclofen – Review of Appendix A, ODG Workers' Compensation Drug Formulary finds Baclofen – Status Y

b. Date of service July 24, 2015, Amitriptyline HCL – Review of Appendix A, ODG Workers' Compensation Drug Formulary finds Amitriptyline HCL Status – Y

c. Date of service July 24, 2015, Amantadine HCL – Review of Appendix A, ODG Workers' Compensation Drug Formulary finds Amantadine HCL Status - Y

d. Date of service July 24, 2015, Gabapentin - Review of Appendix A, ODG Workers' Compensation Drug Formulary finds Gabapentin Status - Y

e. Date of service July 24, 2015, Bupivacaine HCL, Review of Appendix A, ODG Workers' Compensation Drug Formulary finds no listing. Review of Food and Drug Administration, http://www.fda.gov/Drugs/default.html finds Bupivacaine Hydrochloride is not classified as investigational or experimental.

Based on the above the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.503 (c) states,

The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

The services in dispute will be calculated as follows:

| Dates of Service | Prescription Drug | §134.503 (c) (1)(A) | Maximum Allowable Reimbursement |
|---|---|---|---|
| July 24, 2015 | Baclofen | $35.63 x 5 x 125% = $222.69 + $4.00 | $226.69 |
| July 24, 2015 | Amantadine HCL | $24.22500 x 3 x 125% = $90.84 + $4.00 | $94.84 |
| July 24, 2015 | Gabapentin | $59.85 x 4 x 125% = $299.25 + $4.00 | $303.25 |
| July 24, 2015 | Amitriptyline | $18.24 x 2 x 125% = $45.60 + $4.00 | $49.60 |
| July 24, 2015 | Bupivacaine | $45.60 x 1 x 125% = $57.00 + $4.00 | $61.00 |
| | TOTAL | | $735.38 |

3. The total amount allowed for the services in dispute is $735.38. The requestor is seeking $489.96. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | Peggy Miller | December 29, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.